

Patient-centered medical homes in physician-led practices

Health Care: System Efficiency

Benefit-cost estimates updated December 2016. Literature review updated December 2014.

Current estimates replace old estimates. Numbers will change over time as a result of model inputs and monetization methods.

The WSIPP benefit-cost analysis examines, on an apples-to-apples basis, the monetary value of programs or policies to determine whether the benefits from the program exceed its costs. WSIPP's research approach to identifying evidence-based programs and policies has three main steps. First, we determine "what works" (and what does not work) to improve outcomes using a statistical technique called meta-analysis. Second, we calculate whether the benefits of a program exceed its costs. Third, we estimate the risk of investing in a program by testing the sensitivity of our results. For more detail on our methods, see our [Technical Documentation](#).

Program Description: The patient-centered medical home (PCMH) model attempts to make health care more efficient by restructuring primary care. Definitions vary, but PCMHs typically provide health care with the following features: team-based (with team members having defined roles and shared accountability); comprehensive (with the majority of health care needs being addressed); coordinated (across primary care providers, specialists, hospitals, and community service providers); patient-centered (with shared decision-making and support for patient self-management); emphasis on quality and safety (with clinical decision-support tools and methods to track care); and enhanced access (with expanded office hours and shorter waiting times).

This category includes only PCMH programs we reviewed that were implemented in physician-led practices.

Benefit-Cost Summary Statistics Per Participant

Benefits to:

Taxpayers	(\$7)	Benefit to cost ratio	(\$0.74)
Participants	(\$2)	Benefits minus costs	(\$141)
Others	(\$9)	Chance the program will produce	
Indirect	(\$42)	benefits greater than the costs	7 %
<u>Total benefits</u>	<u>(\$60)</u>		
<u>Net program cost</u>	<u>(\$81)</u>		
Benefits minus cost	(\$141)		

The estimates shown are present value, life cycle benefits and costs. All dollars are expressed in the base year chosen for this analysis (2015). The chance the benefits exceed the costs are derived from a Monte Carlo risk analysis. The details on this, as well as the economic discount rates and other relevant parameters are described in our [Technical Documentation](#).

Detailed Monetary Benefit Estimates Per Participant

Benefits from changes to: ¹	Benefits to:				
	Participants	Taxpayers	Others ²	Indirect ³	Total
Health care (total costs)	(\$2)	(\$7)	(\$9)	(\$1)	(\$20)
Adjustment for deadweight cost of program	\$0	\$0	\$0	(\$41)	(\$41)
Totals	(\$2)	(\$7)	(\$9)	(\$42)	(\$60)

¹In addition to the outcomes measured in the meta-analysis table, WSIPP measures benefits and costs estimated from other outcomes associated with those reported in the evaluation literature. For example, empirical research demonstrates that high school graduation leads to reduced crime. These associated measures provide a more complete picture of the detailed costs and benefits of the program.

²"Others" includes benefits to people other than taxpayers and participants. Depending on the program, it could include reductions in crime victimization, the economic benefits from a more educated workforce, and the benefits from employer-paid health insurance.

³"Indirect benefits" includes estimates of the net changes in the value of a statistical life and net changes in the deadweight costs of taxation.

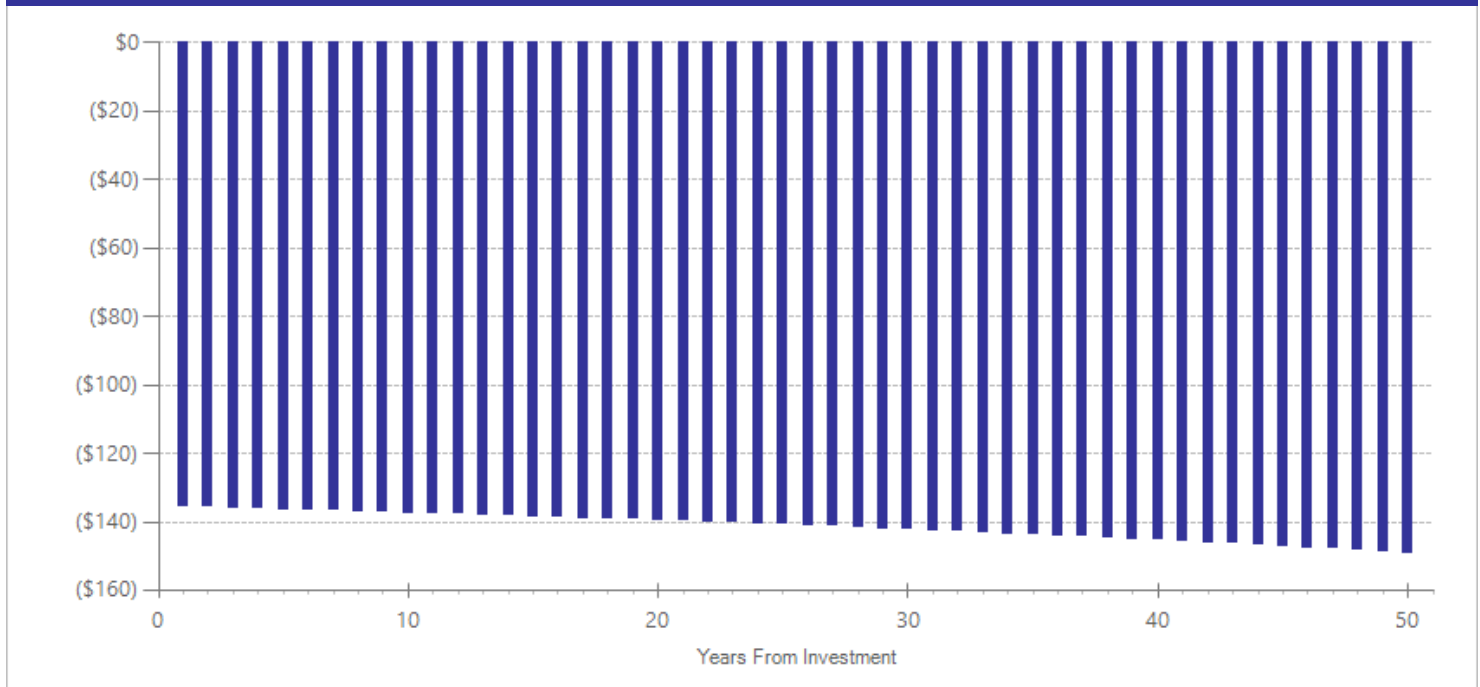
Detailed Annual Cost Estimates Per Participant

	Annual cost	Year dollars	Summary	
Program costs	\$81	2014	Present value of net program costs (in 2015 dollars)	(\$81)
Comparison costs	\$0	2014	Cost range (+ or -)	10 %

We estimated an average per-participant cost based on the additional payments that insurers made to medical providers for implementing medical homes as reported in the studies. These additional payments were made to fund nurse care managers, to provide incentives for achieving patient-centered medical home recognition and quality-of-care targets, and to support other costs incurred in transforming practices.

The figures shown are estimates of the costs to implement programs in Washington. The comparison group costs reflect either no treatment or treatment as usual, depending on how effect sizes were calculated in the meta-analysis. The cost range reported above reflects potential variation or uncertainty in the cost estimate; more detail can be found in our [Technical Documentation](#).

Detailed Annual Cost Estimates Per Participant



The graph above illustrates the estimated cumulative net benefits per-participant for the first fifty years beyond the initial investment in the program. We present these cash flows in non-discounted dollars to simplify the “break-even” point from a budgeting perspective. If the dollars are negative (bars below \$0 line), the cumulative benefits do not outweigh the cost of the program up to that point in time. The program breaks even when the dollars reach \$0. At this point, the total benefits to participants, taxpayers, and others, are equal to the cost of the program. If the dollars are above \$0, the benefits of the program exceed the initial investment.

Meta-Analysis of Program Effects										
Outcomes measured	No. of effect sizes	Treatment N	Adjusted effect sizes and standard errors used in the benefit-cost analysis						Unadjusted effect size (random effects model)	
			First time ES is estimated			Second time ES is estimated				
			ES	SE	Age	ES	SE	Age	ES	p-value
Health care costs	4	59980	0.001	0.006	50	0.000	0.000	51	0.001	0.830

Meta-analysis is a statistical method to combine the results from separate studies on a program, policy, or topic in order to estimate its effect on an outcome. WSIPP systematically evaluates all credible evaluations we can locate on each topic. The outcomes measured are the types of program impacts that were measured in the research literature (for example, crime or educational attainment). Treatment N represents the total number of individuals or units in the treatment group across the included studies.

An effect size (ES) is a standard metric that summarizes the degree to which a program or policy affects a measured outcome. If the effect size is positive, the outcome increases. If the effect size is negative, the outcome decreases.

Adjusted effect sizes are used to calculate the benefits from our benefit cost model. WSIPP may adjust effect sizes based on methodological characteristics of the study. For example, we may adjust effect sizes when a study has a weak research design or when the program developer is involved in the research. The magnitude of these adjustments varies depending on the topic area.

WSIPP may also adjust the second ES measurement. Research shows the magnitude of some effect sizes decrease over time. For those effect sizes, we estimate outcome-based adjustments which we apply between the first time ES is estimated and the second time ES is estimated. We also report the unadjusted effect size to show the effect sizes before any adjustments have been made. More details about these adjustments can be found in our [Technical Documentation](#).

Citations Used in the Meta-Analysis

Boult, C., Reider, L., Leff, B., Frick, K.D., Boyd, C.M., Wolff, J.L., Frey, K., ... Scharfstein, D. (2011). The effect of guided care teams on the use of health services: results from a cluster-randomized controlled trial. *Archives of Internal Medicine*, 171(5), 460-6.

David, G., Gunnarsson, C., Saynisch, P.A., Chawla, R., & Nigam, S. (2014). *Do patient-entered medical homes reduce emergency department visits?* Health Services Research, 5, early online publication.

Fifield, J., Forrest, D.D., Burleson, J.A., Martin-Peele, M., & Gillespie, W. (2013). Quality and efficiency in small practices transitioning to patient centered medical homes: a randomized trial. *Journal of General Internal Medicine*, 28(6), 778-86.

Friedberg, M.W., Schneider, E.C., Friedberg, M.W., Schneider, E.C., Friedberg, M.W., Schneider, E.C., Schneider, E.C., ... Volpp, K.G. (2014). Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. *Journal of the American Medical Association*, 311(8), 815-825.

Rosenthal, M.B. (2013). Effect of a multipayer patient-centered medical home on health care utilization and quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. *Jama Internal Medicine*, 173(20), 1907.

Wang, Q.C., Chawla, R., Colombo, C.M., Snyder, R.L., & Nigam, S. (2014). Patient-centered medical home impact on health plan members with diabetes. *Journal of Public Health Management and Practice*, 20(5), E12-E20.

Werner, R.M., Duggan, M., Duey, K., Zhu, J., & Stuart, E.A. (2013). The patient-centered medical home: An evaluation of a single private payer demonstration in New Jersey. *Medical Care Philadelphia-*, 51(6), 487-493.